What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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INTERACTION AND CONTRACEPTION

Although sub-Saharan Africa remains the only major region of the world with the highest fertility rates, fertility in the region as a whole is now noticeably lower than it was around the late 1970s or later. Discussions about the barriers to rapid fertility decline in this region have highlighted the nature of African reproductive regimes—particularly how they differ from reproductive regimes in other regions. The main consensus on African reproductive regimes appears to be that contraception is one of the key factors underlying fertility decline in Africa. Prominent among factors that have been identified to influence contraceptive use are fertility preferences, increased participation in formal schooling, urbanization, and the diffusion of modern Western culture. The role of diffusion in reproductive change has received great attention in the literature in recent years. Several studies in demography have investigated the role of diffusion in fertility transitions. Underlying these studies is the assumption that the information or behaviour of one person can have spillover effects (positive or negative) on the motivations of another.

Practitioners of nontraditional religions and women with formal education are more likely than others to adopt contraception

Two essential components of diffusion are social learning and social influence. Social learning refers to the acquisition of information from others, which in the case of fertility control, may include information on the types of contraceptive methods available, the health side effects of the methods, and the cost of the methods. At the inter-personal level, social learning takes place when the other actors provide information that shapes an individual's subjective beliefs about prices, qualities, advantages, and health risks of family planning methods. Social influence, on the other hand, refers to the power that individuals exercise over each other through authority, reverence, and social conformity pressures. It is noted that individuals, faced with the need to make decisions in constantly changing environments characterized by ambiguities and uncertainties, rely on information drawn from many sources.

The Community Health and Family Planning Project (CHFP) of the Navrongo Health Research Centre tests the relative effectiveness of alternative strategies for achieving increased contraceptive use and low fertility. The CHFP represents a test of the hypothesis that reproductive ideational change can be introduced in a traditional African society. This note summarizes findings from a study that examined the impact of social interaction (measured by reports of a personal network member with whom family planning has been discussed) on the adoption of contraception in the Kassena-Nankana District.

Launched in 1994, the CHFP is a four-cell experiment designed to evaluate the impact on a health service delivery programme of mobilizing two types of resources—the usual Ministry of Health (MOH) resources and community participation in programme management. The resources are represented by the key staff at the periphery: the Community Health Officers (CHO) who are the MOH nurses relocated to village settings, and Yezura Zenna (YZ) representing community volunteers involved in health promotion. The four cells represent the different combinations of resources that are mobilized. Cell I has YZ only; Cell II has CHO only; Cell III has both CHO and YZ; and Cell IV has a normal MOH service delivery regimen, and is thus a comparison area.

A study which assesses the role of social interaction in contraceptive adoption was carried out on a total of 1,437 currently married women ages 18–49 in 1998 who had not adopted contraception by the time of the survey in 1995

and for whom valid values were available on all variables of interest. In this study, the key outcome variable of interest is contraceptive use in 1998. Contraceptive use has two categories: using at the time of the 1998 survey and not using. The principal explanatory variable is social interaction, measured by discussions of family planning with other individuals and the contraceptive-use motivational role of such individuals as of the time of the survey in 1995. Social interaction is defined strictly in terms of discussions of family planning with individuals other than the husband. In other words, spousal communication is excluded. Several descriptive and statistical procedures were employed in the analysis and the findings of this study can be summarized as follows:


The provision of child health and family planning services through the CHO and YZ enhances demand for contraception

- Generally, older women, women who live in areas with only the MOH services, practitioners of traditional religion, Nankam women, and women who have never attended school are more likely than others to have no social interaction about family planning. In contrast, younger women, women who reside in areas served by the combined activities of the CHO and YZ, practitioners of nontraditional religions, and women who have had some formal education are more likely than others to have interacted with social interaction partners who encourage them to adopt contraception.
- Contraceptive use in 1998 is found to differ significantly by patterns of social interaction in 1995. Women who at the time of the survey in 1995 had discussed family planning with partners who encouraged them to adopt a method are almost three times as likely to use family planning as women who at that time had not discussed family planning with conversational partners.
- Education is also positively correlated with contraceptive use by women who have some formal education—being almost twice as likely as the uneducated to adopt contraception. Furthermore, the intervention programme of providing child health and family planning services through CHO and YZ enhances greater demand for contraception.
- Women who have been encouraged by their discussion partners to use contraception are almost three times as likely as the 'no social interaction' women to adopt contraception. For every contraceptive user among women who have not discussed family planning with social network partners, there are nearly two users among women who have discussed but have not been encouraged by their network partners to adopt family planning.
- Spousal communication about family planning and the encouragement received from health workers and voluntary associations have considerable effects on contraceptive use. Indeed, women who reported that they had been encouraged by health workers are four times as likely as women who reported no such encouragement to adopt contraception.

Conclusion

Results from this study suggest that social interaction about family planning triggers changes in contraceptive behaviour in the Kassena-Nankana District. Furthermore, for the majority of the women, the decision to initiate family planning practice is facilitated by informal discussions with social network partners who encourage contraceptive adoption. This study points to the need for programmes to facilitate social interactions that permit free exchange of ideas and experiences among community members. In addition, programmes should be developed to minimize misconceptions about family planning methods. Adopters should be adequately educated on the benefits and side effects of contraceptive methods as well as the management of these side effects.

Send questions or comments to: What works? What fails?
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